DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 0 6

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $(6,174,822)
b. FFY 2004 $(6,465,130)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19 A, pp 2, 9, 9.1, 13 of 23
Attachment 4.19 B, pp 1, 4, 4.1 of 15
Attachment 4.19 D, Supplement 1, p 26 of 61

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
New pages 4.19 A, 9.1 and 4.19 B, 4.1 ADD
Remaining pages - REPLACE

10. SUBJECT OF AMENDMENT:
Direct Graduate Medical Education; Outpatient Hospital Services Reimbursement; NF Indirect Ceilings and Inflator

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Secretary, Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Patrick W. Finnerty

14. TITLE:
Director

15. DATE SUBMITTED: 8/26/02

16. RETURN TO:
Department of Medical Assistance Service
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Attn: Reg. Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 3, 2002

18. DATE APPROVED: November 22, 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Charlene Brown

22. TITLE: Deputy Director, CMSO

23. REMARKS:

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1. As stipulated in 12 VAC 30-70-231, operating payments for DRG cases that are not transfer cases shall be determined on the basis of a hospital specific operating rate per case times the relative weight of the DRG to which the case is assigned.

2. As stipulated in 12 VAC 30-70-241, operating payments for per diem cases shall be determined on the basis of a hospital specific operating rate per day times the covered days for the case with the exception of payments for per diem cases in freestanding psychiatric facilities. Payments for per diem cases in freestanding psychiatric facilities licensed as hospitals shall be determined on the basis of a hospital specific rate per day that represents an all-inclusive payment for operating and capital costs.

3. As stipulated in 12 VAC 30-70-251, operating payments for transfer cases shall be determined as follows: (i) the transferring hospital shall receive an operating per diem payment, not to exceed the DRG operating payment that would have otherwise been made and (ii) the final discharging hospital shall receive the full DRG operating payment.

4. As stipulated in 12 VAC 30-70-261, additional operating payments shall be made for outlier cases. These additional payments shall be added to the operating payments determined in subdivisions 1 and 3 of this subsection.

5. As stipulated in 12 VAC 30-70-271, payments for capital costs shall be made on an allowable cost basis.

6. As stipulated in 12 VAC 30-70-281, payments for direct medical education costs of nursing schools and paramedical programs shall be made on an allowable cost basis. Payment for direct Graduate Medical Education (GME) costs for interns and residents shall be made quarterly on a prospective basis, subject to cost settlement based on the number of full time equivalent (FTE) interns and residents as reported on the cost report.

7. As stipulated in 12 VAC 30-70-291, payments for indirect medical education costs shall be made quarterly on a prospective basis.

8. As stipulated in 12 VAC 30-70-301, payments to hospitals that qualify as disproportionate share hospitals shall be made quarterly on a prospective basis.

C. The terms used in this article shall be defined as provided in this subsection:

"Base year" means the state fiscal year for which data is used to establish the DRG relative weights, the hospital case-mix indices, the base year standardized operating costs per case, and the base year standardized operating costs per day. The base year will change when the DRG payment system is re-based and re-calibrated. In subsequent re-basing, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

"Base year standardized costs per case" reflects the statewide average hospital costs per discharge for DRG cases in the base year. The standardization process removes the effects of case-mix and regional variations in wages from the claims data and places all hospitals on a comparable basis. Base

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result in an expenditure for outlier operating payments equal to 5.1% of total operating payments, including outlier operating payments, for DRG cases. The methodology described in subsection A of this section shall be applied to all base year DRG cases on an aggregate basis, and the amount of the outlier operating fixed loss threshold shall be calculated so as to exhaust the available pool for outlier operating payments.

12 VAC 30-70-270. Repealed.

12 VAC 30-70-271. Payment for capital costs.

A. Capital costs shall continue to be paid on an allowable cost basis and settled at the hospital's fiscal year end, following the methodology described in Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130).

B. The exception to the policy in subsection A of this section is that the hospital specific rate per day for services in freestanding psychiatric facilities licensed as hospitals, as determined in 12 VAC 30-70-321 B, shall be an all-inclusive payment for operating and capital costs.

C. Until prospective payment for capital costs is implemented, the provisions of 12 VAC 30-70-70 regarding recapture of depreciation shall remain in effect.

12 VAC 30-70-280. Repealed.

12 VAC 30-70-281. Payment for direct medical education costs of nursing schools, paramedical programs, and graduate medical education for interns and residents.

A. Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis. Payments for these direct medical education costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

B. Final payment for these direct medical education (DMedEd) costs shall be the sum of the fee-for-service DMedEd payment and the managed care DMedEd payment. Fee-for-service DMedEd payment is the ratio of Medicaid inpatient costs to total allowable costs, times total DMedEd costs. Managed care DMedEd payment is equal to the managed care days times the ratio of fee-for-service DMedEd payments to fee-for-service days.

C. Effective with cost reporting periods beginning on or after July 1, 2002, direct Graduate Medical Education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis, subject to cost settlement as outlined in subdivision E of this section.

D. The new methodology provides for the determination of a hospital-specific base period per-resident amount to initially be calculated from cost reports with fiscal years

ending in state fiscal year 1998 or as may be re-based in the future and provided to the public in an agency guidance document. This per-resident amount shall be calculated by dividing a hospital's Medicaid allowable direct GME costs for the base period by its number of interns and residents in the base period yielding the base amount.

E. The base amount shall be updated annually by the DRI-Virginia moving average values as compiled and published by DRI•WEFA, Inc. (12 VAC 30-70-351). The updated per-resident base amount will then be multiplied by the weighted number of full time equivalent (FTE) interns and residents as reported on the annual cost report to determine the total Medicaid direct GME amount allowable for each year. Payments for direct GME costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end based on the actual number of FTEs reported in the cost reporting period. The total Medicaid direct GME allowable amount shall be allocated to inpatient and outpatient services based on Medicaid's share of costs under each part.

F. Direct medical education shall not be a reimbursable cost in freestanding psychiatric facilities licensed as hospitals.

12 VAC 30-70-290. Repealed.

12 VAC 30-70-291. Payment for indirect medical education costs.

A. Hospitals shall be eligible to receive payments for indirect medical education. These payments recognize the increased use of ancillary services associated with the educational process and the higher case-mix intensity of teaching hospitals. The payments for indirect medical education shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

B. Final payment for IME shall be determined as follows:

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12 VAC 30-70-350. Repealed.

12 VAC 30-70-351. Updating rates for inflation.

Each July, the DRI-Virginia moving average values as compiled and published by DRI•WEFA, Inc. under contract with the department shall be used to update the base year standardized operating costs per case, as determined in 12 VAC 30-70-361, and the base year standardized operating costs per day, as determined in 12 VAC 30-70-371, to the midpoint of the upcoming state fiscal year. The most current table available prior to the effective date of the new rates shall be used to inflate base year amounts to the upcoming rate year. Thus, corrections made by DRI•WEFA, Inc. in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming state fiscal year.

12 VAC 30-70-360. Repealed.

12 VAC 30-70-361. Base year standardized operating costs per case.

A. For the purposes of calculating the base year standardized operating costs per case, base year claims data for all DRG cases, including outlier cases, shall be used. Base year claims data for per diem cases shall not be used. Separate base year standardized operating costs per case shall be calculated for Type One and Type Two hospitals. In calculating the base year standardized operating costs per case, a transfer case shall be counted as a fraction of a case based on the ratio of its length of stay to the arithmetic mean length of stay for cases assigned to the same DRG as the transfer case.

B. Using the data elements identified in subsection E of 12 VAC 30-70-221, the following methodology shall be used to calculate the base year standardized operating costs per case:

1. The operating costs for each DRG case shall be calculated by multiplying the hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-221.

2. The standardized operating costs for each DRG case shall be calculated as follows:

a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the non-labor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs.

c. The standardized labor portion of operating costs shall be added to the non-labor portion of operating costs, yielding standardized operating costs.

3. The case-mix neutral standardized operating costs for each DRG case shall be calculated by dividing the standardized operating costs for the case by the hospital's case-mix index.

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§1. General. The policy and the method to be used in establishing payment rates for each type of care or service (other than inpatient hospitalization, skilled nursing and intermediate care facilities) listed in §1905(a) of the Social Security Act and included in this State Plan for Medical Assistance are described in the following paragraphs:

1. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the Plan at least to the extent these are available to the general population.

2. Participation in the program will be limited to providers of services who accept, as payment in full, the state's payment plus any co-payment required under the State Plan.

3. Payment for care or service will not exceed the amounts indicated to be reimbursed in accord with the policy and methods described in the Plan and payments will not be made in excess of the upper limits described in 42 CFR 447.304(a). The state agency has continuing access to data identifying the maximum charges allowed: such data will be made available to the Secretary, HHS, upon request.

§2. Services which are reimbursed on a cost basis.

A. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program with the exception provided for in subdivision 2 c of subsection D below. The upper limit for reimbursement shall be no higher than payments for Medicare patients on a facility by facility basis in accordance with 42 CFR 447.321 and 42 CFR 447.325. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be non-covered as a component of payment to the facility.

B. Reasonable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

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(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

c. Outpatient reimbursement methodology. DMAS shall continue to reimburse for outpatient hospital services, with the exception of direct graduate medical education for interns and residents, at 100% of reasonable costs less a 10 percent reduction for capital costs and a 5.8 percent reduction for operating costs.

d. Payment for direct medical education costs of nursing schools, paramedical programs and graduate medical education for interns and residents:

(1) Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

(2) Effective with cost reporting periods beginning on or after July 1, 2002, direct Graduate Medical Education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis. See 12 VAC 30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

3. Rural health clinic services provided by rural health clinics or other federally qualified health centers defined as eligible to receive grants under the Public Health Services Act §§329, 330, and 340.

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4. Rehabilitation agencies. Reimbursement for physical therapy, occupational therapy, and speech-language therapy services shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the NF or any other available source, and provided further, that this amendment shall in no way diminish any obligation of the NF to DMAS to provide its residents such services, as set forth in applicable provider agreement.

5. Comprehensive outpatient rehabilitation facilities

6. Rehabilitation hospital outpatient services.

5.1. Inpatient psychiatric inpatient psychiatric services in residential treatment facilities (under EPSDT). Effective January 1, 2000, the state agency shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers, under the terms and payment methodology described below.

A. Methodology. Effective January 1, 2000, payment will be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by the state agency based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute payment for all residential psychiatric treatment facility services, excluding all professional services.

rates before the sale.

I. Public notice. To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

12VAC30-90-41.1 Modifications to Nursing Facility Reimbursement Formula.

1. Effective on and after July 1, 2002, the indirect operating ceiling as referenced at 12VAC30-90-41.A.5 shall be set at 103.9%, of the referenced indirect operating cost median as determined from the cost reports for the base year 2000.

2. Effective on July 1, 2002 and for only State Fiscal Year 2003, the adjustment for inflation of indirect operating cost ceilings and indirect operating cost rates as referenced at 12VAC30-90-41.B shall be made using an inflation percentage of 0%. The effective result is that no inflation adjustment will be applied to determine the indirect operating cost ceilings and/or the indirect operating cost rates applicable during State Fiscal Year 2003.

3. The provisions of this section 12VAC30-90-41.1 shall supersede the applicable provisions in 12VAC30-90-41.

12VAC30-90-42. Repealed.

12VAC30-90-43. Repealed.

12VAC30-90-44 to 12VAC30-90-49. Reserved.

Article 5
Allowable Cost Identification

12VAC30-90-50. Allowable costs.

A. Costs which are included in rate determination procedures and final settlement shall be only those allowable, reasonable costs which are acceptable under the Medicare principles of reimbursement, except as specifically modified in the Plan and as may be subject to individual or ceiling cost limitations and which are classified in accordance with the DMAS uniform chart of accounts (see 12VAC30-90-270).

B. Certification. The cost of meeting all certification standards for NF requirements as required by the appropriate state agencies, by state laws, or by federal legislation or regulations.